

WISCONSIN MEDICAID
PRESUMPTIVE ELIGIBILITY FOR THE FAMILY PLANNING WAIVER (FPW)
(ONLY FOR WOMEN AGES 15 THROUGH 44)

*The Wisconsin Medicaid Program requires personal information to enable the Medicaid program to authorize and pay for medical services provided to eligible recipients. Providing or applying for a Social Security Number is voluntary; however any person who wants Wisconsin Medicaid but does not want to provide their SSN or apply for one will not be eligible for benefits, pursuant to Wisconsin Statutes s. 49.82(2).

SECTION I — NON-FINANCIAL ELIGIBILITY

Client Information	Preferred language (other than English) in which to receive benefit information:		
1. Name — Client (Last, First, MI)	Birth Date (MM/DD/YY)	Telephone Number	
2. Residence Address (Street/P.O. Box, City, State, Zip Code)	County of Residence		
3. Are you currently receiving full-benefit Wisconsin Medicaid / BadgerCare? (If Yes, stop here.)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
4. Have you been determined presumptively eligible for the FPW in the last 12 months? (If Yes, stop here.)	<input type="checkbox"/> YES <input type="checkbox"/> NO		
5. Are you an U.S. citizen? (If No, stop here.)	<input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION II — FINANCIAL ELIGIBILITY

1. How many family members, in the same household, live on this income? Include the number of medically verified fetuses.	1.
2. Enter the total monthly gross earned income. This is the amount of money earned monthly before any deductions. Include spouse's income. Do not count the parents' income for a minor who is applying. NOTE: Include any self-employment expenses (use monthly average).	2. \$
3. Enter total monthly unearned income (VA, SSA, contributions, unemployment compensation, allowance, etc.).	3. \$
4. Enter the total monthly gross income (add Lines 2 and 3).	4. \$
5. Enter monthly allowable work-related expense deduction for each employed household member.	5. \$
6. Enter monthly allowable dependent care expense.	6. \$
7. Enter any monthly amount of child support actually paid; up to amount ordered by the court.	7. \$
8. Enter total allowable deductions (add Lines 5, 6, and 7).	8. \$
9. Enter total net income (subtract Line 8 from Line 4).	9. \$
10. Compare the total net income (Line 9) with the federal poverty level guideline for the appropriate group size. Does the client meet the eligibility income limits?	<input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION III — NOTICE

1. <input type="checkbox"/> I certify that the above-named client, based on the preliminary information provided above, is presumptively eligible for the Wisconsin Medicaid FPW. I have informed her of the requirement to apply by mail, telephone or in person at her county/tribal social or human services department, W-2 agency, or Medicaid outstation site by the end of the second month following the current month. I have informed her of all privacy issues under the FPW.		
OR		
<input type="checkbox"/> I have determined that the above-named client is not presumptively eligible for the Wisconsin Medicaid FPW for the following reason(s) <div style="display: flex; justify-content: space-between;"><div><input type="checkbox"/> She does not qualify under the age guidelines. <input type="checkbox"/> She is currently eligible for Wisconsin Medicaid. <input type="checkbox"/> She was determined PE for the FPW in the past 12 months (can only have one PE certification for FPW in 12-month period).</div><div><input type="checkbox"/> She is not a U.S. citizen. <input type="checkbox"/> She does not qualify under the income guidelines.</div></div>		
Name — Qualified Provider (Type or Print)		Address — Qualified Provider
SIGNATURE — Qualified Provider		Medicaid Provider Number Date Signed
2. <input type="checkbox"/> I certify, under penalty of false swearing, that the information on this application and given in connection with it is a true and complete statement of facts according to my best knowledge and belief. I understand that in order to be determined eligible for Wisconsin Medicaid, I must apply by mail, telephone, or in person at a county/tribal social or human services department, W-2 agency, or Medicaid outstation site. I understand that presumptive eligibility for the FPW ends at the end of the second month following the month in which I was determined presumptively eligible for the FPW.		
OR		
<input type="checkbox"/> I understand that I do not meet the eligibility requirements for presumptive eligibility for the Wisconsin Medicaid FPW. The qualified provider named above has informed me that I may still apply for Wisconsin Medicaid by mail, telephone, or in person at a county/tribal social or human services department, W-2 agency, or Medicaid outstation site.		
SIGNATURE — Client		Date Signed

SECTION IV — TEMPORARY IDENTIFICATION CARD

This card identifies you as being presumptively eligible to receive family planning-related care through the Wisconsin Medicaid Family Planning Waiver. You may receive these services from any Medicaid certified provider participating in the Family Planning Waiver. You must present this card before receiving care.	Card Validity Dates		Med Stat Category	Identification Number*	Agency Code Number
	From	Through	PF		
	Client Name and Mailing Address for all Correspondence (Street / P.O. Box, City, State, Zip Code)			This card entitles this individual to receive family planning-related care through the Wisconsin Medicaid Family Planning Waiver from any Medicaid certified provider participating in the Family Planning Waiver program during the time period listed. The individual listed has been determined presumptively eligible for the Wisconsin Medicaid Family Planning Waiver in accordance with s.49.45, Wis. Stats.	
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